Carroll County Health Department

Public Health
Prevent. Promote. Protect.

Respite Care Services Application

Name: First: _____ **Middle**: _____**Last**: _____
DOB: __/__/____ **Age**: _____**School or daycare**: _____
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other
Are you Hispanic or Latino? ☐ Yes ☐ No

Eligibility Criteria: (please check ALL that apply)
☐ Children and youth, ages birth-21;
☐ Enrolled in school (including post-secondary education; pre-school; day care) Yes ___No___
☐ Reside in Carroll County;
☐ Have an identified developmental disability and/or behavioral or social/emotional disability
☐ Does the child currently receive Special Education Services? Yes___ No ___
If yes; IEP Yes___ No___ or 504 Plan Yes___ No___
☐ Without the funding would otherwise not be able to participate in respite camp/activity.

Parent or Guardian Contact:
Name: _____ Relationship _____
Address: _____
Phone: _____ E-mail Address: _____

Respite Care provider /Camp/Activity Information:
Name: _____
Address: _____
Phone: _____ Respite/Camp Contact Person: _____
Dates of respite care/camp/activity: _____Cost: _____**Total Funding requested:** $_____

The following supporting documentation MUST BE ATTACHED to this checklist:
☐ Copy of proof of disability (i.e. IEP, 504 Plan, doctor letter, etc.)
☐ Copy of camp registration form or respite activity*
Please note that the Carroll County Health Department will not be responsible for registering the child for camp, this action must be completed by the Parent/Guardian. CCHD will only make payment to the identified camp and must have a contact at the camp to coordinate payment.

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CONSENT TO RELEASE INFORMATION

I, _____, consent that Carroll County Health Department, Maternal Child Health/Nursing Program will review Respite Care Checklist and Supporting documentation to determine eligibility for respite funds. If approved, I further agree that Carroll County Health Department, Maternal Child Health/Nursing Program may forward the payment to the identified camp in order to be eligible for the grant program. Camper funds will be granted on a first come first serve basis. This consent will remain in effect for 1 (one) year or may be rescinded in writing at any time.

_____ _____
Parent/Guardian Date

For CCHD Office Use Only

_____ _____
Signature Date
Approved ☐ Yes ☐ No Reason for denial: _____

Revised 03/21/2019